Building Resilient Health Systems to Advance toward Universal Health in the Americas

Lessons from COVID-19

PAHO Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

Building Resilient Health Systems to Advance toward Universal Health in the Americas:
Lessons from COVID-19

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Introduction

Universal access to health and universal health coverage (universal health) means that all people and communities have access, without discrimination, to comprehensive, appropriate, and timely quality health services, medicines, and other health technologies, without suffering financial hardship.

Universal health is not just about ensuring that everyone has coverage, but that people have effective access to health services when they need it, wherever they are, including interventions for healthy living. It requires multisectoral and coordinated policies and actions to address the social determinants of health and promote a society-wide commitment to fostering health and well-being.

The COVID-19 pandemic has reaffirmed that universal health, based on primary health care, constitutes the foundation for resilient health systems that have the capacity to prepare for and respond effectively to crises, maintaining core functions when a crisis hits, and reorganizing and transforming if conditions require it.

This brochure presents a summary of the situation of health systems and services in the Americas as they progress toward the achievement of universal health. The information provided presents an overview of the situation before the COVID-19 pandemic, how the pandemic has impacted health systems, and recommendations to address current and future challenges.

Health Systems and Services before COVID-19

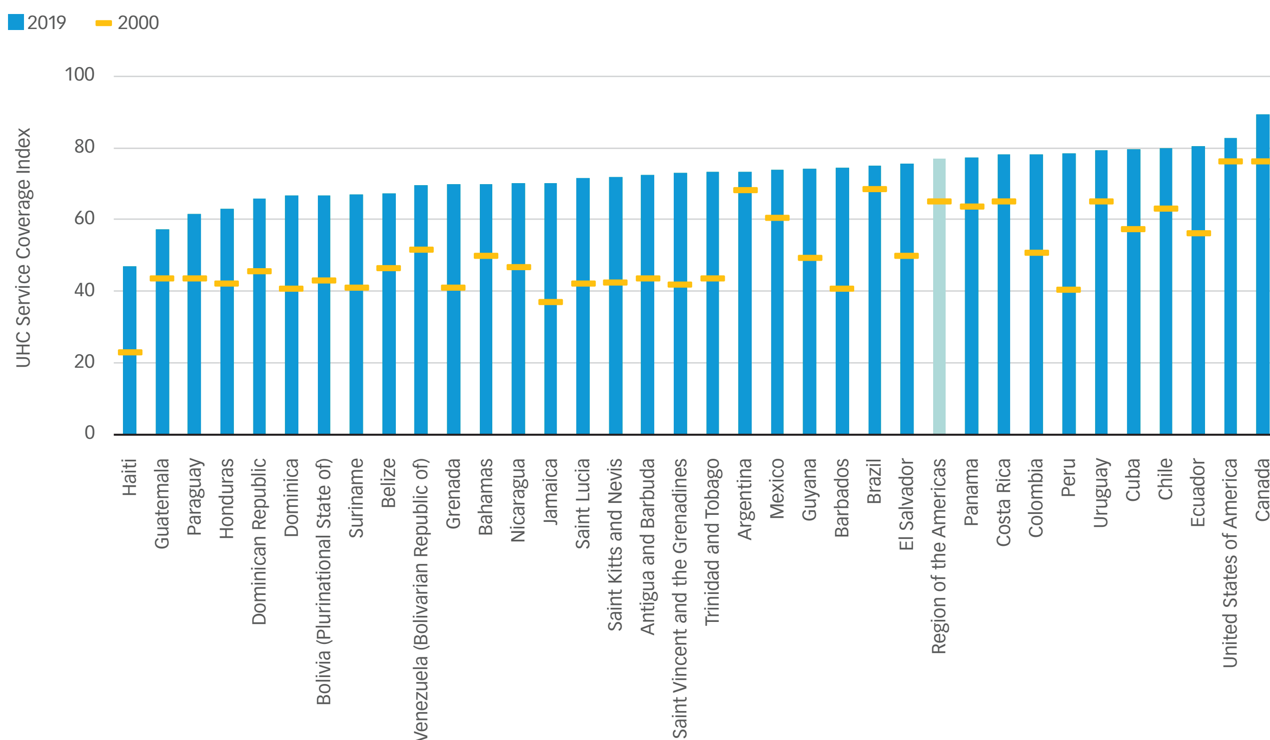
Before the COVID-19 pandemic, the Region of the Americas was making steady progress toward the achievement of universal access to health and universal health coverage, but systemic deficiencies and inequalities persisted, and gains were slow.

Service coverage was improving

The Sustainable Development Goal (SDG) 3.8.1 target on service coverage, as measured by the UHC service coverage index (SCI), improved regionally from a population-weighted average of 65 in 2000 to 77 in 2019, reaching the third-highest average value across World Health Organization (WHO) regions (Figure 1). This improvement, along with other socioeconomic factors, accompanied important health gains, as exemplified by the increase in the regional average life expectancy at birth from 73.7 to 77.0 years over the same period.

In 2019 in the Region of the Americas, the UHC SCI average value ranged from 47 to 89 across 35 Member States. Of these countries, 5 had very high service coverage (index of 80 and above), 28 had high coverage (index between 60 and 79), and 2 had medium coverage (index between 40 and 59). No country had low coverage (index between 20 and 39) or very low coverage (index below 20). While the Region recorded the lowest absolute gains of 12 points over the period 2000–2019, more than 60% of

FIGURE 1. UHC SCI, Region of the Americas, 2000 and 2019



Source: World Health Organization [Internet]. Geneva: WHO; 2022 [cited 2022 Aug 25]. The Global Health Observatory. UHC Service Coverage Index (SDG 3.8.1). Available from: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage.

countries (22 of 35 countries) experienced an increase in index values greater than 20 index points. When looking at the four UHC SCI subcomponents, the infectious diseases subindex improved the fastest between 2000 and 2009 (from 48 to 81), while the reproductive, maternal, newborn, and child health (RMNCH), noncommunicable diseases, and service and access components experienced slower gains.

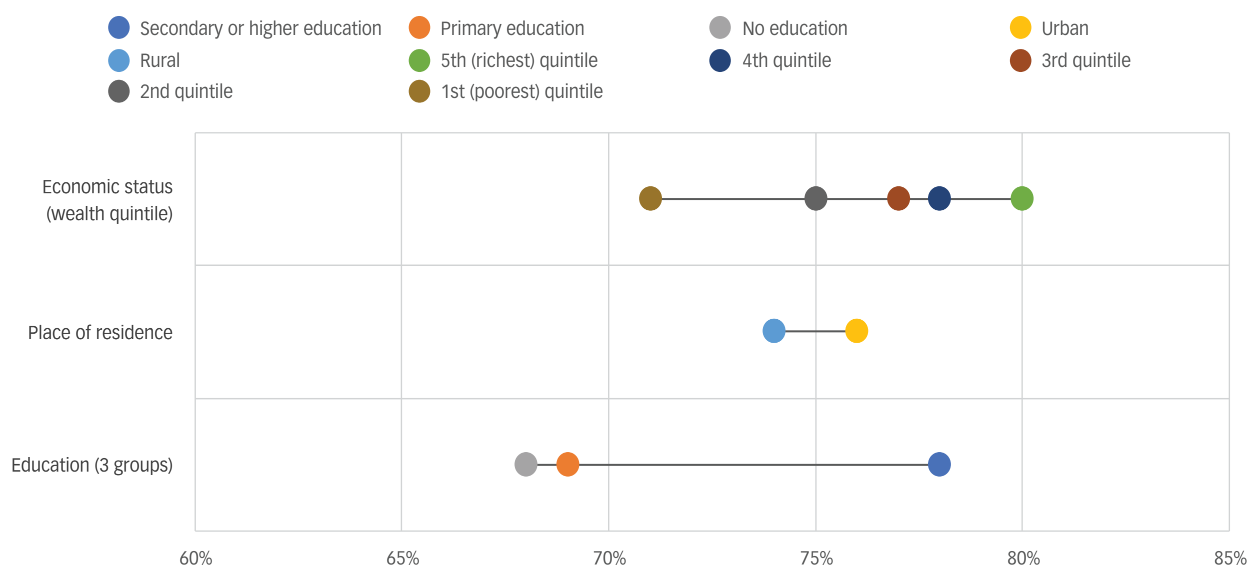
Inequalities in service coverage persisted

Lack of disaggregated data represents a major challenge to measuring inequalities in UHC SCI in the Region. However, inequalities across subgroups of the population can be monitored for several lower and upper middle-income countries using the RMNCH composite coverage index. This index, which is different from the RMNCH subindex of the UHC SCI, is calculated from primary data from Demographic and Health Surveys or Multiple Indicator Cluster Surveys. Within countries, RMNCH coverage tends to be higher among more advantaged groups, such as in the highest income group, the most educated, or those living in urban areas. For instance, data from 10 countries of the Region indicate a median coverage of 80.0% among the highest income population quintile compared with a median coverage of 71.0% among the poorest quintile (Figure 2). There are similar patterns for inequalities related to education level and place of residence.

People continued to face multiple barriers to access health services

Data from 17 countries in the Americas show that 34.4% of the population experienced unmet care needs due to multiple access barriers. On average, the percentage of unmet needs was higher among individuals in the poorest income quintile than the richest quintile (36.9% compared to 30.0%). Of those who reported a health care need, financial, availability, and administrative barriers were, on average, the

FIGURE 2. RMNCH composite coverage index, by multiple dimensions of inequality, Region of the Americas, 2015–2019



Note: Latest situation (2015–2019); regional simple average.

Source: World Health Organization [Internet]. Geneva: WHO; 2022 [cited 2022 Aug 25]. Health Inequality Monitor. Inequality in reproductive, maternal, newborn and child health. Available from: https://www.who.int/data/inequality-monitor/data/interactive-data-visualizations-rmnch.

most common reasons for unmet care needs (Figure 3). At the same time, people in the poorest income quintile were those most likely to experience barriers related to acceptability issues, financial and geographical access, or availability of resources. These results highlight the need for integrated and multisectoral approaches aimed at reducing barriers to access health services, such as cost, coverage issues, lack of time, inadequate availability of resources, and low willingness to seek care due to cultural and linguistic reasons—each of which may require a specific and tailored policy approach.

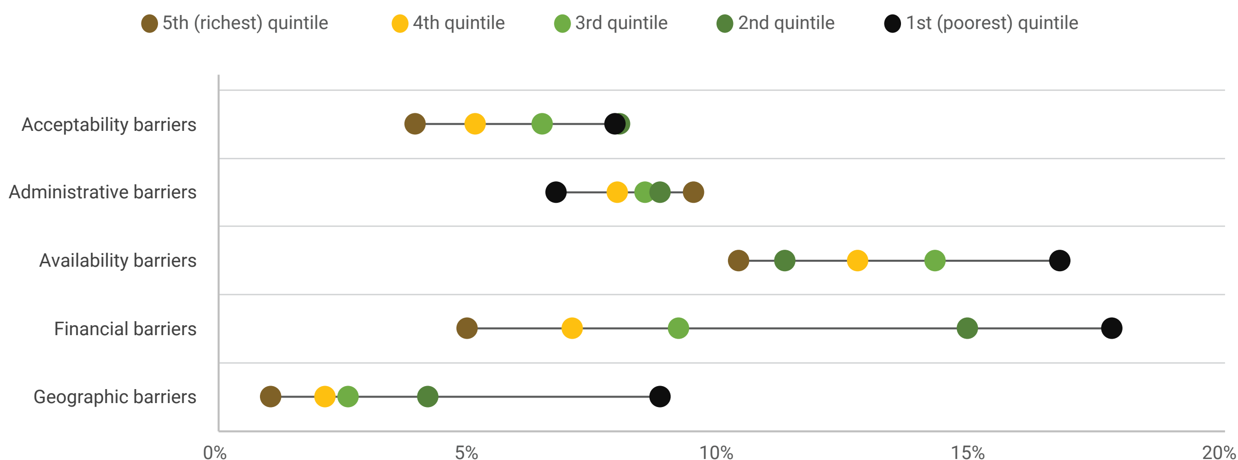
Catastrophic and impoverishing health expenditure decreased, but unequally

People seeking care face financial barriers that contribute to delayed or forgone care. Also, when people use health services, they can experience financial hardship as a result of direct payments or out-of-pocket payments at the point of service. The percentage of the population in the Region of the Americas spending more than 10% of their household budget on health, as tracked by SDG indicator 3.8.2, increased by 1.2 points between 2000 and 2010 (Table 1), although the Americas was the only WHO region that experienced reductions in the incidence of catastrophic health spending between 2010 and 2017. In addition, the number of people incurring impoverishing health spending decreased continuously from 0.5% in 2000 to 0.1% in 2017, based on the extreme poverty line. People living in poor households and in households with older members (those aged 60 and older) were more likely to face financial hardship because of out-of-pocket payments for health care. To reduce inequalities in financial hardship, it is critical to protect people in situations of vulnerability through effective financial protection mechanisms and progressive health financing mechanisms.

Public investment in health increased significantly but was still insufficient

Public spending in health in Latin America and the Caribbean (LAC) slowly improved, although spending was still insufficient to replace out-of-pocket as a source of funding and to build more equitable and efficient resilient health systems. On average, public health spending as a share of gross domestic product (GDP) increased from 2.8% in 2000 to 3.9% in 2019, an

FIGURE 3. Unmet health care needs, by type of access barrier and income quintile, Region of the Americas, 2011–2019



Note: Latest situation (2011–2019); regional simple average.

Source: World Health Organization. Tracking Universal Health Coverage: 2021 Global monitoring report. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240040618.

increase of 1.1 percentage points. In addition, most LAC countries were below the regionally agreed threshold of 6% of GDP. Reliance on out-of-pocket spending was trending downward, dropping from an average of 40.3% in 2000 to 32.2% in 2019 (Figure 4). In addition to limited public spending, low priority was given to investments at the first level of care. As highlighted in the Regional Compact on Primary Health Care (PHC) for Universal Health, PHC 30-30-30, prioritizing investments at the first level of care is a necessary condition to improve its resolutive capacity and provide quality health services to people and communities.

Availability of human resources for health improved, but the deficit remained unacceptably high

Recent estimates on human resources for health (HRH) availability and density thresholds required to meet the SDG 3.8.1 target showed that LAC countries had a regional physician density of 19.5 (14.6–25.5) and a nurse and midwife density of 44.3 (34.5–55.9) per 10,000 population. To reach the high aspirational target of 80% on the UHC effective coverage index, it was calculated that at least 20.7 physicians, 70.6

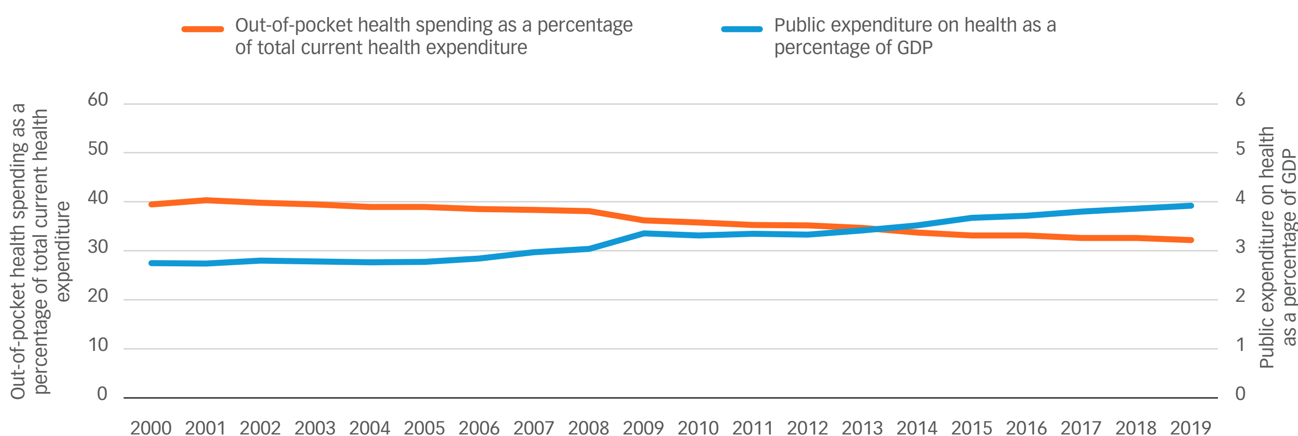
TABLE 1. **Population suffering financial hardship, Region of the Americas, 2000–2017 (%)**

SDG-related indicators	2000	2010	2017
SDG indicator 3.8.2, 10% threshold	**6.6**	**7.8**	**7.1**
SDG indicator 3.8.2, 25% threshold	**1.1**	**1.3**	**1.3**
Pushed below a poverty line (PPP $1.90 a day)	**0.5**	**0.3**	**0.1**
Further pushed below a poverty line (PPP $1.90 a day)	**2.6**	**1.7**	**0.5**

Note: PPP, purchasing power parity.

Source: World Health Organization; World Bank. Global monitoring report on financial protection in health 2021. Geneva: WHO and The World Bank; 2021. Available from: https://www.who.int/publications/i/item/9789240040953.

FIGURE 4. Public expenditure on health and out-of-pocket health spending, Latin America and the Caribbean, 2000–2019



Note: Simple average.

Source: World Health Organization [Internet]. Geneva: WHO; 2022 [cited 2022 Aug 22]. Global Health Expenditure Database. Available from: https://apps.who.int/nha/database.

nurses and midwives, 8.2 dentistry personnel, and 9.4 pharmaceutical personnel per 10,000 population would be needed. Between 66.0% and 93.9% of LAC countries fell short of these minimum thresholds in 2019 (Table 2). Using a different UHC index and methodology, WHO had previously estimated a projected deficit of at least 600,000 health professionals in the Region of the Americas in 2030. Noting the methodological and threshold differences, all these findings highlight the crucial need for increased investments in education and employment conditions of HRH to achieve universal health and global health security.

Despite improved regulatory capacity, access to medicines and other health technologies remains a challenge

As the percentage of the regional population with health coverage increases, demand for medicines and other health technologies in benefits packages is also increasing, including for more complex health technologies. The collective Latin American pharmaceuticals market is predicted to grow 7% in the period 2018–2023, making it the second-fastest growing regional market globally. The fastest-growing areas include hepatitis C and HIV, oncology, and immunotherapy (Figure 5). Many of the new products in these areas are expensive biologics that will increasingly strain government budgets. As a consequence of this trend, countries are systematically applying health technology assessment, with 18 countries with formal established mechanisms. Across therapeutic areas of medium and low growth, most products are accessed through community pharmacy settings. Given the lack of financial protection, out-of-pocket expenditures on medicines and other health technologies are expected to increase considerably.

The use of generic essential medicines is core to providing cost-effective and efficient health care. The penetration of generic medicines in pharmaceutical markets indicates opportunities for improving efficiencies and reducing costs without compromising quality of care. But in Latin American countries with regulatory authorities of regional reference, generic medicines appear to make up less than a third of the pharmaceuticals market, compared to 90% by volume in the United States of America. Recent reforms, however, in national regulatory authorities have brought important improvements in access to medicines and transparency within the authorities. As a result, regulatory capacity for medicines in the Americas is improving, with over 82% of the population now living in a country with a national regulatory authority of regional reference.

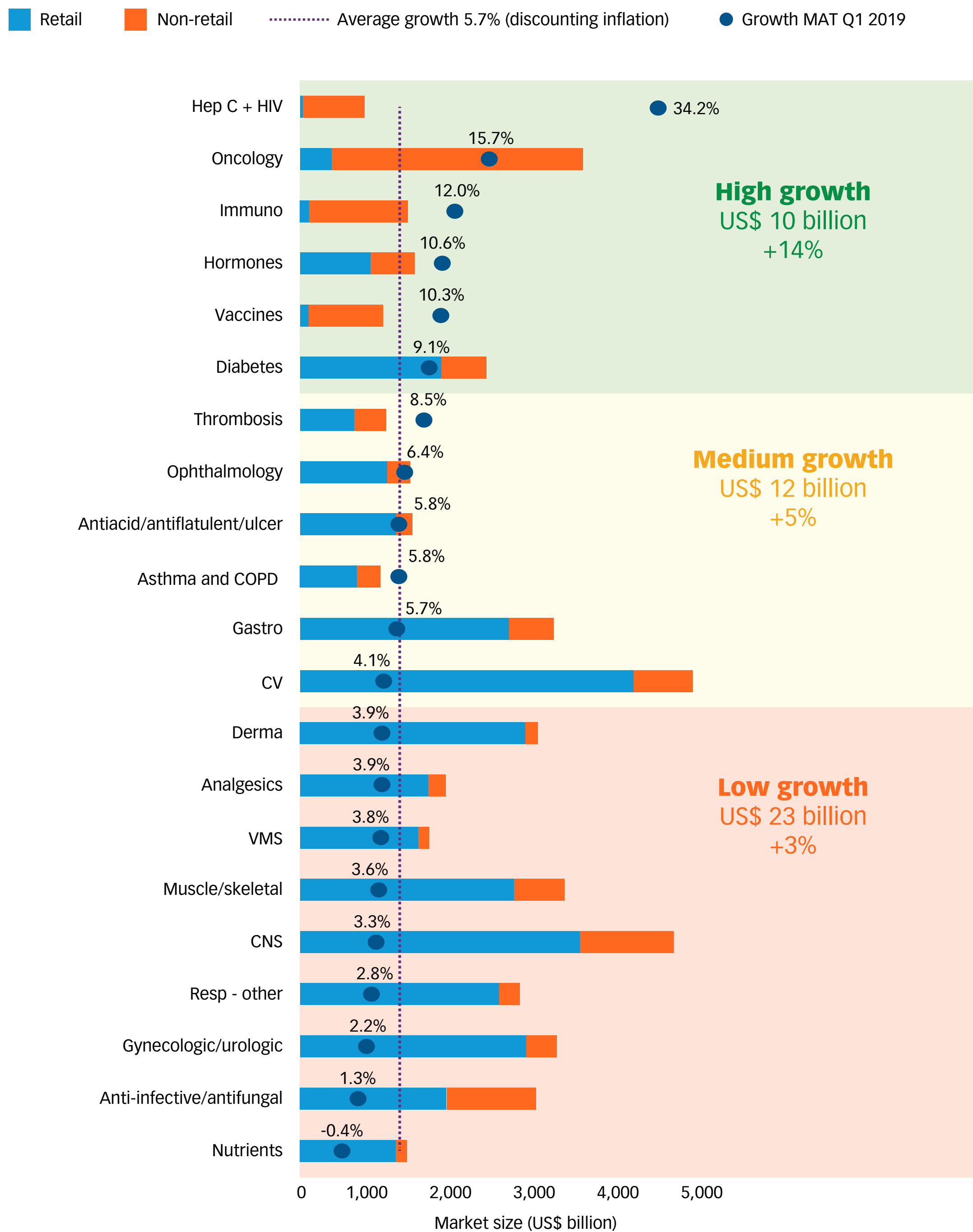
TABLE 2. **Shortage of human resources for health, Latin America and the Caribbean, 2019**

	NUMBER OF COUNTRIES WITH SHORTAGE	PROPORTION OF COUNTRIES WITH SHORTAGE[a] (%)	SUM OF COUNTRY-LEVEL SHORTAGES (NUMBER OF WORKERS)
Physicians (threshold: 20.7 per 10,000 population)	22	66.7%	238,000
Nurses and midwives (threshold: 70.6 per 10,000 population)	31	93.9%	1,570,000
Dentistry personnel (threshold: 8.2 per 10,000 population)	23	69.7%	32,800
Pharmaceutical personnel (threshold: 9.4 per 10,000 population)	28	84.8%	263,000

Note: [a] Represents the proportion of countries and territories in LAC that have a shortage of four HRH cadre groups at UHC effective coverage of 80 out of 100 on the UHC coverage index.

Source: GBD 2019 Human Resources for Health Collaborators. Measuring the availability of human resources for health and its relationship to universal health coverage for 204 countries and territories from 1990 to 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2022;399(10341):2129–54. https://doi.org/10.1016/S0140-6736(22)00532-3.

FIGURE 5. Growth dynamics of different therapeutic areas, Latin America



Notes: Latin American pharmaceutical market (US$ billion) – audited market. Countries surveyed: Argentina, Brazil, Chile, Colombia, Ecuador, Mexico, and Peru. Data sources: Retail Market MIDAS MAT Q1 2019 with Brazil @ price PPP; NRC Brazil MAT Q1 2019 @ 2nd price level; SISMED Colombia MAT Q1 2019; Mexico NRC+GSDT MAT Mar-19 @ ex-manufacturer price level; NRC Ecuador MAT Q1 2019; NRC market in other countries estimated (ARG, Central America, CHL, PER). Growths calculated in constant US$ exchange rates. Exchange rates: ARG 38.87; BRA 3.77; CHL 667; COL 3,135; ECU 1.00; MEX 19.21; PER 3.32.

Source: Pan American Health Organization. Regulatory System Strengthening in the Americas: Lessons Learned from the National Regulatory Authorities of Regional Reference. Washington, DC: PAHO; 2021. Available from: https://iris.paho.org/handle/10665.2/53793.

Health Systems and Services and the COVID-19 Pandemic

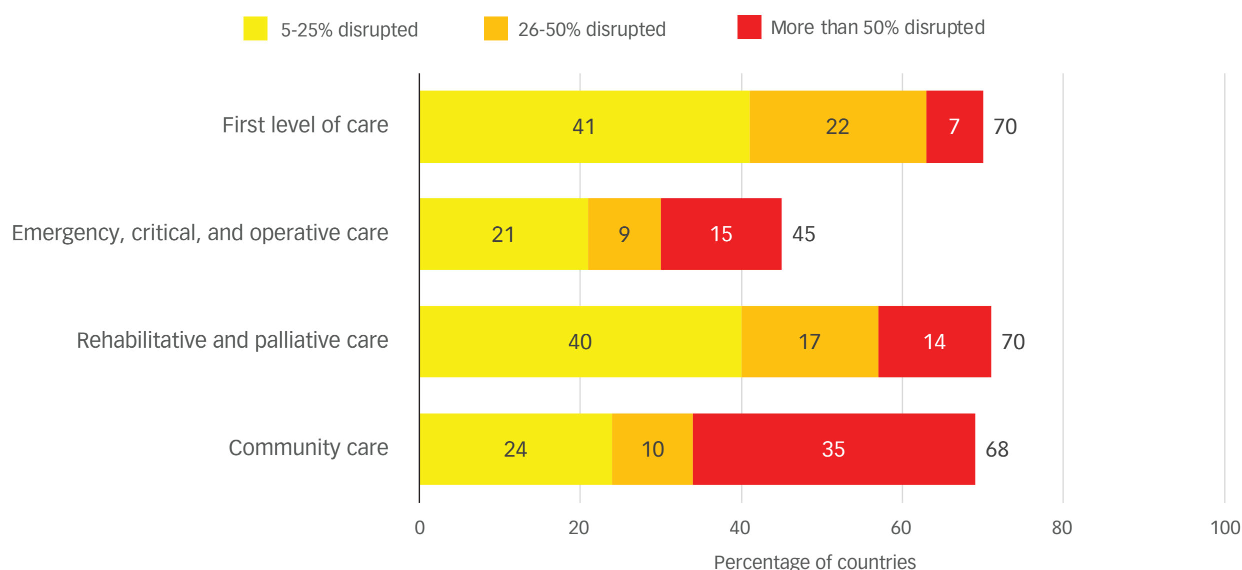
The pandemic has reversed progress made toward the achievement of universal access to health and universal health coverage exposing and exacerbating structural weaknesses of health systems and health inequalities.

Despite efforts, ensuring the continuity of essential health services continues to be a challenge

By July 2022, the Region of the Americas had reported more than 163 million cases of COVID-19 and close to 3 million deaths. Two years into the pandemic, nearly all countries in the Region continue to report disruptions to essential health services (EHS), with 93% of 28 countries reporting disruptions of at least one essential service during the preceding six months.

Notably, the magnitude and extent of disruptions in the delivery of EHS have not substantially improved since Q3 2020, even though countries have intensified efforts to respond to health systems bottlenecks and barriers to access created by the COVID-19 pandemic. In Q4 2021, disruptions were reported across all health service delivery platforms, with the first level of care and community-based care services among the most affected areas (Figure 6). In addition, countries continue to report disruptions across all priority health areas, with over half of countries reporting disruptions to immunization, care for older people, and cancer care (Figure 7). These disruptions have affected access to critical health services, especially for the most vulnerable populations. Notably, all countries have implemented strategies and innovations to overcome

FIGURE 6. Percentage of countries (n=20) reporting disruptions in the provision of essential health services, by service delivery channels, June–November 2021



Source: Pan American Health Organization. Third round of the National Survey on the Continuity of Essential Health Services during the COVID-19 Pandemic: November–December 2021. Washington, DC: PAHO; 2022. Available from: https://iris.paho.org/handle/10665.2/56128.

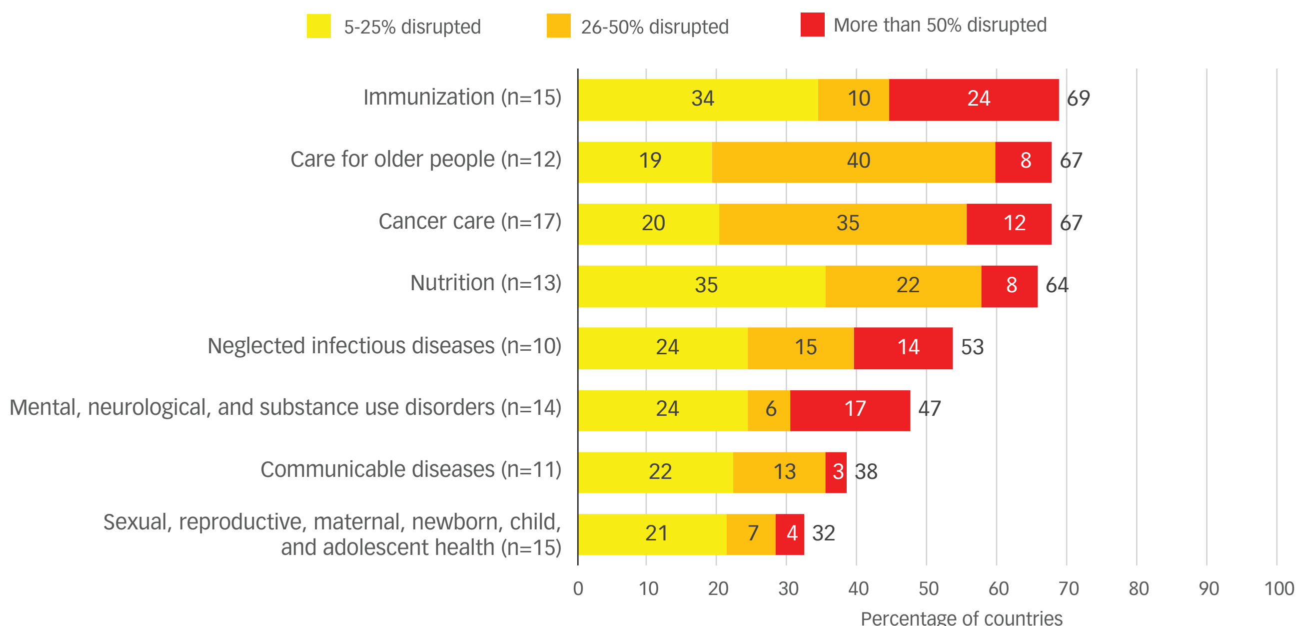
disruptions and increase health service capacity to provide COVID-19 tools and essential health services. These include increasing the number of beds for critical care, strengthening the first level of care for testing, contact tracing, and isolation, introducing experiences on integrated health service networks, shifting to community-based care and engagement, and an unprecedented digital transformation of health.

Disruptions in the supply of medicines and other health technologies highlight dependence on imports

The pandemic has led to shortages and inequities in access to essential medicines (pharmaceuticals and vaccines) and other health technologies (personal protective equipment, diagnostics, biomedical equipment), limiting or jeopardizing the delivery of EHS. The health crisis has revealed the dependence of LAC on imports of medicines and other health technologies from outside the Region, the vulnerability of global supply chains in emergencies, and the high degree of heterogeneity in the Americas in terms of COVID-19 vaccine research, development, and production capacity. The pandemic has also impacted blood supply. Comparing blood collection in 2019 and 2020, seven of the 17 Latin American countries had a reduction of between 20% and 40% in the number of units collected. No country reported critical events or situations due to shortages.

There were also challenges regarding the use of COVID-19 treatments without quality evidence. For example, five countries in the Region reported approximately 3,400 adverse reactions to medicines such as azithromycin, ivermectin, and hydroxychloroquine used in COVID-19, highlighting a need to apply more rigorous processes in the selection, evaluation, and incorporation of medicines in health systems. On the other hand, innovation was observed through multi-month prescribing and dispensing of medicines for high-risk populations, including people living with HIV. This strategy prevented unnecessary high-risk contacts with saturated health services and contributed to improved treatment adherence.

FIGURE 7. Percentage of countries (n = 20) reporting disruptions in the provision of essential health services, by priority health areas, June–November 2021



Source: Pan American Health Organization. Third round of the National Survey on the Continuity of Essential Health Services during the COVID-19 Pandemic: November–December 2021. Washington, DC: PAHO; 2022. Available from: https://iris.paho.org/handle/10665.2/56128.

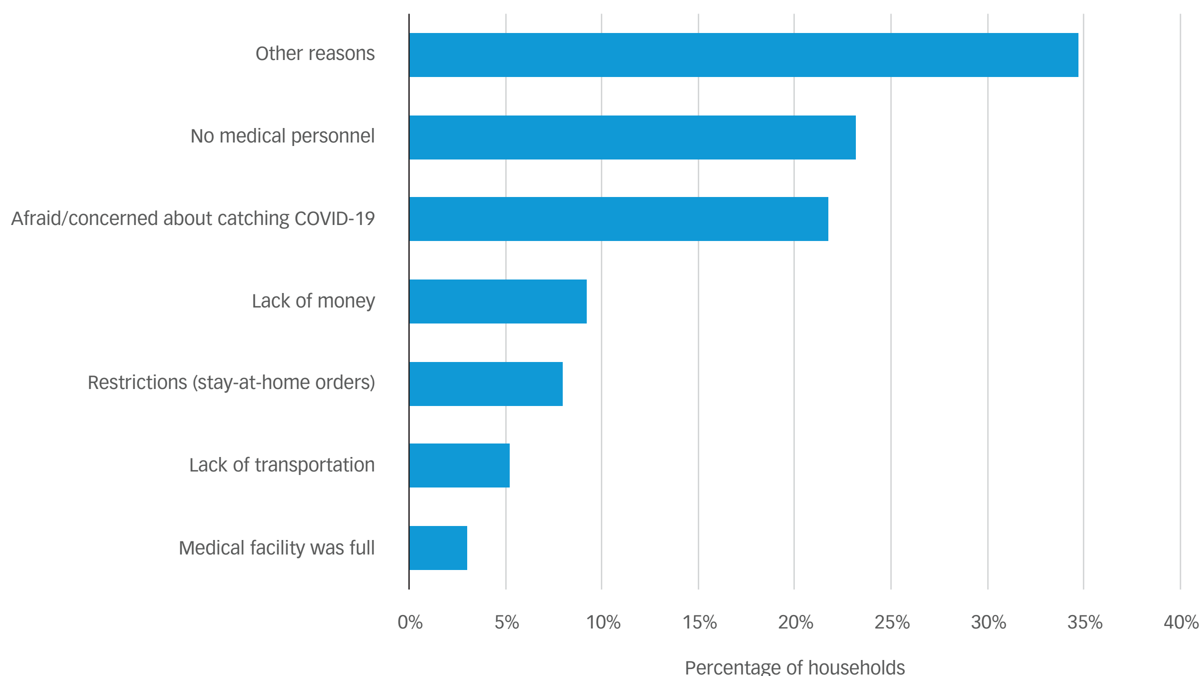
The pandemic worsened existing barriers to access health services and created new ones

The PHC 30-30-30 Compact calls for reducing access barriers by at least 30%, progressively by 2030. The effects of the pandemic on the provision of EHS combined with the socioeconomic crisis indicate significant worsening of access conditions, leading to delayed and forgone care, expressed by higher incidence of unmet needs due to both supply-side and demand-side barriers (Figure 8). Data from national pulse surveys highlight a mix of factors responsible for disruption to services, including lack of HRH (34% of countries), intentional service delivery modifications (34% of countries), and decreased care-seeking (32% of countries). As well as struggling to maintain EHS, most countries in the Region reported critical challenges to scaling up access to essential COVID-19 tools due to issues of HRH availability and distribution, adverse mental health impacts on HRH on the front line of the pandemic response efforts, shortages in supply and equipment, and community demand-side challenges. These findings emphasize the need for increasing health workforce capacity for health service delivery, prioritizing their mental health and well-being, adapting care pathways for both COVID-19 and non-COVID-19 patients, and community-based and health promotion strategies to address demand-side challenges. As far as possible, additional resources are needed to sustain and expand the delivery of EHS, prioritizing the first level of care.

COVID-19 vaccination rates have improved, but disruptions in routine immunization services have increased

As of 19 August 2022, 69.3% of the population of the Americas had been fully vaccinated with at least two doses of COVID-19 vaccine. However, progress of vaccination coverage has been slow and uneven

FIGURE 8. Main reasons for not accessing health care when needed, Latin America and the Caribbean

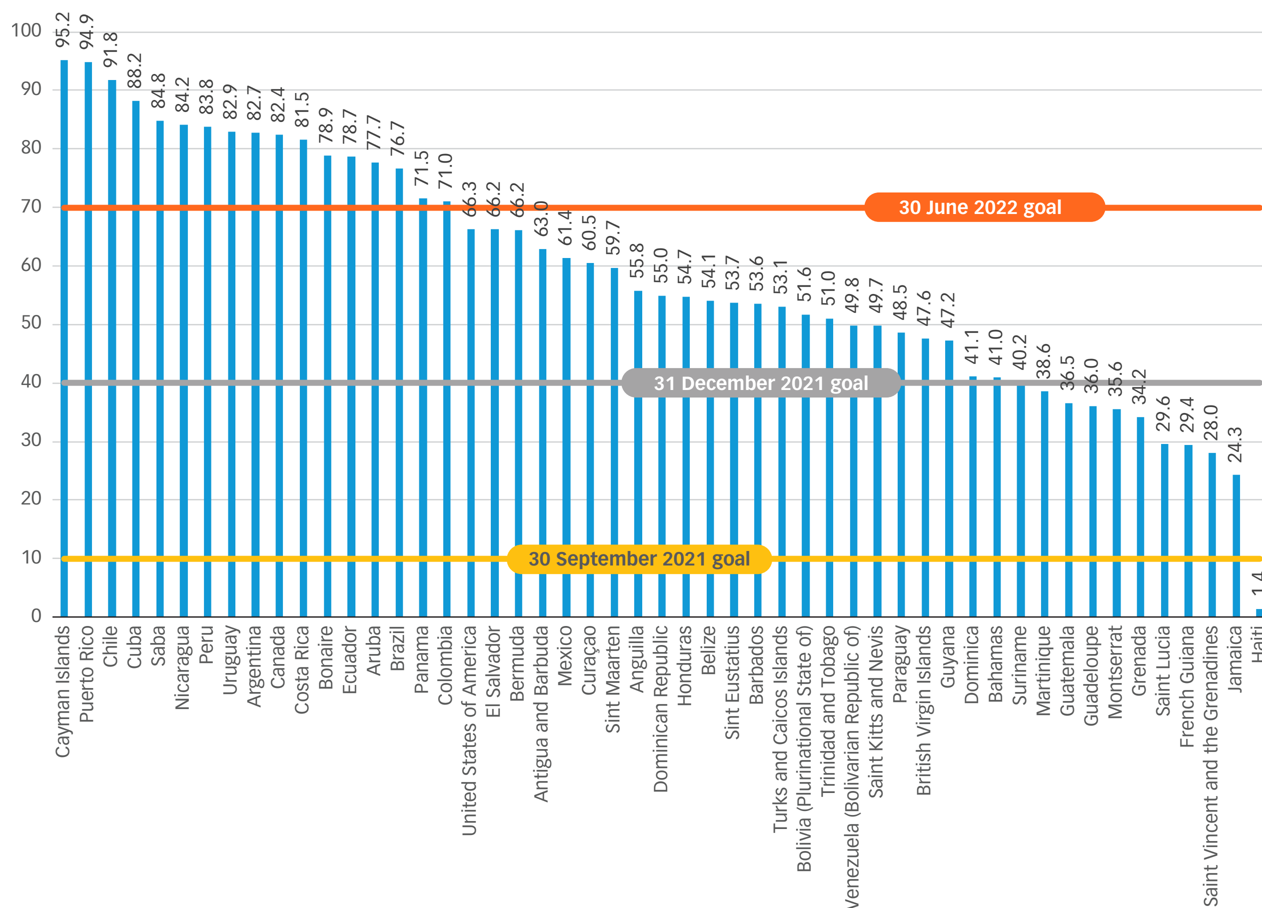


Source: Calculations using data from the World Bank High Frequency Phone Survey. Data collected from households between May 2020 and August 2020. The World Bank [Internet]. Washington, DC: World Bank; 2022 [cited 2022 Aug 22]. COVID-19 Household Monitoring Dashboard. Available from: https://www.worldbank.org/en/data/interactive/2020/11/11/covid-19-high-frequency-monitoring-dashboard.

across the Region (Figure 9). In addition, the majority of COVID-19 vaccine doses applied since October 2021 have been booster doses, which do not contribute to the national vaccination coverage rate.

Immunization coverage levels have suffered greatly during the COVID-19 pandemic. In 2020, limited access to first level of care services and supply chain disruptions contributed to the decline. In 2021, governments' intense focus on COVID-19 vaccination operations shifted financial and human resources away from the national immunization programs, further reducing the regional vaccination coverage rate for routine antigens. The same year, WHO and UNICEF data showed that the percentage of children who received three doses of the vaccine against diphtheria, tetanus, and pertussis (DTP3)—a marker for immunization coverage within and across countries—fell 4 percentage points between 2019 and 2021 to 80%, the lowest in the Americas since 2011. In total, more than 2.7 million children under 1 year of age in the Americas (19.7%) did not receive all their vaccine doses, leaving them susceptible to diseases such as polio, tetanus, measles, and diphtheria.

FIGURE 9. Population with completed COVID-19 vaccination schedule, Region of the Americas, 19 August 2022 (%)

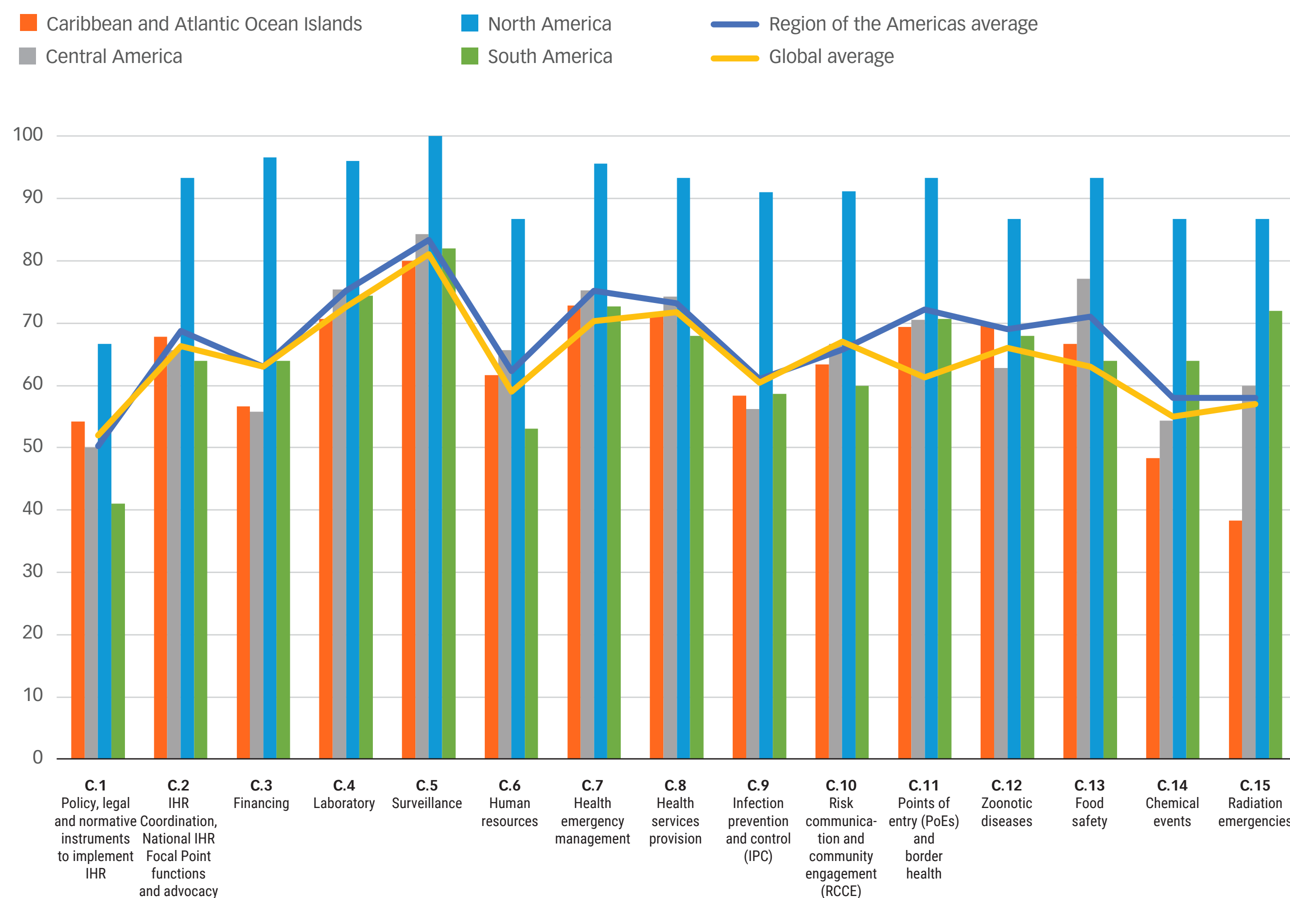


Source: Pan American Health Organization [Internet]. Washington, DC: PAHO; 2022 [cited 2022 Aug 22]. COVID-19 Vaccination in the Americas. Available from: https://ais.paho.org/imm/IM_DosisAdmin-Vacunacion.asp.

More sustained efforts are needed to maintain and strengthen IHR core capacities

As reported to the 75th World Health Assembly in 2021, the regional score for all capacities necessary to effectively implement the International Health Regulations 2005 (IHR) was 67%, compared to the global average of 65%, although scores varied highly across subregions of the Americas (Figure 10). Among the 15 core capacities, the strengths in the Region were in surveillance (83%), laboratory (75%), and health emergency management (75%), while the challenges were in policy, legal, and normative instruments to implement IHR (50%), chemical events (58%), and radiation emergencies (58%). The challenges by indicators were: gender equality in health emergencies (44%), workforce surge during a public health event (54%), policy, legal, and normative instruments (57%), financing for IHR implementation (58%), safe environment in health facilities (58%), resources for detection and alert (58%), and capacity and resources (58%). These results highlight the need to adopt the essential public health functions approach to promote effective and equitable responses and maintain and improve IHR core capacities.

FIGURE 10 IHR score per capacity, Region of the Americas, by subregion, 2021



Note: Based on 32 countries that have submitted reports using the e-SPAR tool.

Source: World Health Organization [Internet]. Geneva: WHO; 2022 [cited 2022 Aug 22]. e-SPAR State Party Annual Report. IHR score per capacity. Available from: https://extranet.who.int/e-spar/#capacity-score.

Recommended Actions

The COVID-19 pandemic has highlighted the urgent need for the transformation of health systems to achieve universal access to health and universal health coverage, based on PHC, as the foundation to build more resilient health systems and societies in the Americas. In addition, universal health can only be achieved by promoting universal social protection that supports poverty alleviation and by addressing the social determinants of health. There is thus a need to accelerate and scale up coordinated actions across health and other sectors, including social and economic development sectors, to promote systemic transformations.

The Pan American Health Organization is supporting its Member States in the implementation of four lines of action to develop resilient health systems and recover public health gains during post-COVID-19.

In addition to supporting the immediate response to the crisis, the implementation of these lines of action must be embedded in efforts to recover and sustainably develop health systems, reducing structural vulnerabilities and expanding access, in order to address future health needs and be better prepared to respond to future crises.

Transform health systems, based on a PHC approach, to accelerate pandemic recovery, recuperate and sustain public health gains, and retake the path toward universal health:

- Accelerate health systems transformation based on a PHC approach that addresses the needs of people, families, and the communities where they live, through comprehensive, integrated, quality care.
- Ensure a continuum of services ranging from health promotion and disease prevention through screening, early diagnosis, treatment, rehabilitation, and supportive care.
- Seek to influence health determinants, with an explicit emphasis on intersectoral interventions and actions to address the social, environmental, and economic determinants of health throughout the life course.
- Foster inclusive social participation, including coordination across sectors and stakeholders.
- Renew the commitments to implement the recommendations of the PHC 30-30-30 Compact of reducing barriers to access by 30%, increasing public financing, and allocating at least 30% of these resources to the first level of care by 2030.

Strengthen leadership, stewardship, and governance through a renewed focus on the essential public health functions:

- Adopt a whole-of-government and whole-of-society approach to enhance public health capacities and to design and strengthen institutional structures that can coordinate different public health interventions and programs across sectors.
- Strengthen State institutions, with a view to guaranteeing the population's right to health.
- Improve management and coordination to leverage the capacity of all subsystems and sectors (public and private), promoting greater integration.
- Improve the design and implementation of policies set in stronger legislative and regulatory frameworks, including addressing risk factors and the social determinants of health.
- Strengthen national processes in the evaluation, selection, and rational use of medicines, and national regulatory capacity to ensure the safety, quality, and efficacy of medicines and other health technologies.
- Develop and implement integrated policies across health, science and technology, and industry to increase manufacturing capacity for medicines and other health technologies.
- Ensure State structures and agencies responsible for performing the essential public health functions have sufficient and trained HRH, adequate infrastructure and technological support, and sufficient and sustainable financing.
- Institutionalize monitoring, evaluation, and accountability mechanisms that legitimize stronger and greater interaction between civil society and the functions of the State.

Strengthen capacities of health service delivery networks to expand access and improve preparedness and response to public health emergencies:

- Develop capacities for adaptability, response, and reorganization of the health services network, including health services' surge capacity.
- Strengthen the organization of health services to restore and strengthen access to EHS by reconstructing the health services network, so that most health needs can be resolved at the first level.
- Increase management capacity of health networks and establish mechanisms to coordinate care along the continuum of health services based on people's needs.
- Strengthen the response capacity of the first level of care, including the assessment and rapid adoption of evidence-based innovations in health services to restore EHS and offset access barriers to health services.
- Strengthen the capacity of health service networks to support the delivery of comprehensive, quality health services (both for individuals and populations) and to improve the acceptability and responsiveness of health services.
- Ensure access to medicines and other health technologies in the design and delivery of comprehensive health services, including through the strengthening of the supply and value chain.
- Improve planning and management of human resources, including incentives and policies for retention that address decent working conditions and support requirements for HRH, including mental health services.
- Strengthen interprofessional health teams at the first level of care and the formation of specialists to ensure continuity of care throughout the health care network.
- Adopt digital solutions to enhance access to health services, including those tools employed during the COVID-19 pandemic.

Increase and sustain public financing in health and social protection, including for actions to address the social, environmental, and economic determinants of health:

- Boost public investment to overcome structural vulnerabilities in financing. This requires increasing public health expenditure to 6% of GDP, consolidating its financial sustainability, and reducing out-of-pocket payments at the point of service.
- Prioritize investments in the first level of care, allocating at least 30% of total public expenditure in health to the first level, as proposed by the PHC 30-30-30 Compact.
- In the short term, increase health spending in real terms, particularly in the public component, to meet the new needs generated by the pandemic and strengthen the provision of other EHS.
- Capital investments and recurrent expenditures are needed in national budgets to maintain and enhance public health functions.
- Strengthen capacities in planning and public financial management for health systems and reduce segmentation to improve efficiency of financing.
- Enhance capacities in costing, budgeting, and allocation of resources, including alignment of various funding sources to fully finance national health plans/response plans, and in a manner that is sustainable and predictable.

This brochure presents a summary of the situation of health systems and services in the Americas as they progress toward the achievement of universal access to health and universal health coverage (universal health). The information provided presents an overview of the situation before the COVID-19 pandemic, how the pandemic has impacted health systems, and recommendations to address current and future challenges for building resilient health systems to advance toward universal health in the Americas.

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